

SOLOMON ISLANDS

GLOBAL AIDS RESPONSE PROGRESS REPORT 2016



**MINISTRY OF HEALTH AND MEDICAL SERVICES
STI/HIV DIVISION**

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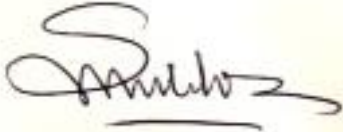
FOREWORD

At the June 2011 United Nations General Assembly High Level Meeting on AIDS which took place in New York, Member States adopted a new Political Declaration which contained new targets to effectively respond to the AIDS epidemic. The 2011 Political Declaration mandates UNAIDS to support countries in reporting back on progress made towards achieving the new commitments. It also provides for the UN Secretary-General to report regularly to the General Assembly on progress achieved in realizing these commitments.

In 2015, Solomon Islands continued its commitment to the 2011 Political Declaration through reviewing and aligning the National Strategic Plan for HIV/AIDS and STIs to the Declaration of Commitment on HIV/AIDS of 2011, identifying the country priorities and making estimations for the resource needs. We are proud of many activities implemented during the years to ensure wide information dissemination, advocacy, education and availability of HIV Testing and Counselling to all citizens of Solomon Islands which has brought us to the present state where the national emphasis is now shifting to quality of services.

Below is the official report for 2014 submitted by the Government of Solomon Islands to the UNAIDS Secretariat for the monitoring of progress towards the targets set in the 2011 Political Declaration on HIV/AIDS. This submission will form part of the basis of the UN Secretary-General's report to the General Assembly as well as the 2015 End of Year Report on the Global AIDS Epidemic.

Thank you



.....
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National STI/HIV Coordinator

Ministry of Health and Medical Services

STATEMENT BY THE MHMS ON THE OFFICIAL SUBMISSION

This report on the progress made in the Solomon Islands AIDS response between January and December 2015 and it highlights the achievements, challenges and lessons learnt in the Solomon Islands AIDS response in the thematic areas of Prevention, Treatment, Care and Support as well as Health Systems Strengthening.

The report was written by the HIV/STI Division of the Ministry of Health and Medical services, with technical support from Opwonya Sam Obwona, a UNICEF HIV/AIDS Consultant.

I therefore take this opportunity to convey our great appreciation to the HIV/STI Division team for their contributions to this report, and to UNICEF for the continued technical and financial support towards the national response.

Thank you.



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Dr. Tenneth Dalipanda

Permanent Secretary

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ACRONYMS AND ABBREVIATIONS

AHC	Area Health Clinics
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOP	Annual Operational Plan
AOR	Adjusted Odds Ratio
ART	Anti Retroviral Therapy
ARV	Anti Retroviral drugs
BCC	Behavioural Change Communication
CPT	Cotrimoxazole Preventive Therapy
CSO	Civil Society Organisation
CPR	Contraceptive Prevalence Rate
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic and Health Survey
EVA	Especially Vulnerable Adolescents
FBO	Faith Based Organisation
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
GESI	Gender Equity and Social Inclusion
GFP	Gender Focal Point
GoA	Government of Australia
HBsAg	Hepatitis B surface Antigen
HCC	Honiara City Council
HIES	Household Income and Expenditure Survey
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSP	Health Sector Support Programme
IEC	Information Education and Communication

IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partner Violence
KAP	Knowledge Attitude and Practice
KPI	Key Performance Indicator
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR	Multi Drug Resistant
MHMS	Ministry of Health and Medical Services
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men having Sex with Men
MWYCFA	Ministry of Women, Youth, Children and Family Affairs
NCD	Non Communicable Diseases
NDS	National Development Strategy
NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
NMS	National Medical Stores
NRH	National Referral Hospital
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
PHC	Primary Health Care
PICT	Pacific Island Countries and Territories
PITC	Provider Initiated Testing and Counselling
PLWD	Persons Living with Disease
PLHIV	Persons Living with HIV
PNG	Papua New Guinea
PWD	Persons With Disabilities
PMTCT	Prevention of Mother To Child Transmission of HIV
PoC	Point of Care
PPTCT	Prevention of Parent To Child Transmission of HIV
PS	Permanent Secretary
PSC	Public Service Commission
RHC	Rural Health Clinic

RDP	Role Delineation Policy
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RPR	Rapid Plasma Reagin
RWASH	Rural Water, Sanitation and Hygiene
SGSS	Second Generation Sentinel Survey
SI	Solomon Islands
SIFHS	Solomon Islands Family Health and Safety Study
SIG	Solomon Islands Government
SINAC	Solomon Islands National AIDS Council
SINCCM	Solomon Islands National Country Coordinating Mechanism
SIPPA	Solomon Islands Planned Parenthood Association
SPC	Secretariat of the South Pacific
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TPHA	Treponema Pallidum Haemagglutination Assay
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organisation

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I. STATUS AT A GLANCE

Solomon Islands has low HIV incidence and prevalence. Since the first HIV case was diagnosed in 1994, a total of 25 cases have been officially recorded. However, HIV data have relied almost exclusively on client-initiated testing and counselling at voluntary at HIV Testing Centres. This passive way of HIV testing is likely to reflect significant under-reporting, as uptake of HIV Testing services has been very low due to limited availability of services – e.g. due to frequent stockouts of rapid test kits and limited access to health services for much of the majority of rural people – as well as due to strong stigma surrounding HIV and AIDS, which makes people reluctant to go for an HIV test. Thus, the low number of HIV cases found to date reflects the very limited testing that has been done so far: the most recent HIV/STI surveillance study among ANC women revealed that only 14 percent had ever been tested for HIV, with a mere 7.6 percent in the last 12 months (MHMS, 2015b). In a study among ANC women and youth in 2008, only 3.4 percent reported they had ever been tested (MHMS, 2008). Reasons given for not getting tested included the unavailability of testing services, fears that friends or neighbours will find out; lack of confidentiality and inaccessibility of the HIV Testing Centre. In this context, the 10-year period from 1994 to 2004 without new reported cases reflects the impact of limited availability and uptake: no testing results in zero reported cases.

Furthermore, results from three HIV/STI surveillance studies among ANC women (and in 2008 including young people) in 2004/05, 2008 and 2015 found no HIV cases, which is an indicator that HIV prevalence among the general population is still very low. In other countries with low prevalence or concentrated epidemics, HIV rates among key populations, such as sex workers and men who have sex with men (MSM) are often considerably higher. However, in Solomon Islands no special research on HIV prevalence among these groups has been done; although behavioural studies reveal very high rates of sexual risk behaviours among these groups, as well as among a considerable proportion of young people. HIV in Solomon Islands is thought to be primarily heterosexually driven, as there is no evidence of infections among MSM or of injecting drug use. More details on HIV risk factors are discussed below.

While HIV rates are very low, very high STI rates in Solomon Islands reveal that the underlying behavioural risks are high, with a real potential for a future increase in HIV cases. Table (2) shows the results from routine testing in ANC services in 2014, which reveal very high rates of syphilis: the overall rate is 13.5 percent, with particularly high rates of 30.6 percent in Western Province; and higher rates among the 15-24 year old group than in the 25+ group (15.8% vs. 11.8%).

The Status of the Epidemic

Solomon Islands has to date had 28 cumulative cases of HIV dating from 1994 to the end of 2015, with all but one of these cases having been identified since 2004, 3 (2 males and 1 female) of them diagnosed in 2015. As at the end of 2014, 10 (7 males and 3 females) of the Persons Living with HIV/AIDS had died from AIDS related causes., 10 (2 males and 8 females) were receiving antiretroviral therapy, 3(2 males and 1 female) were lost to follow-up after missing their appointments due to travel or relocation and the remaining 2 (both female) are not on treatment. Of the two females not on ART, one refused treatment whereas the other isn't yet eligible for treatment as per the ART Guidelines being used, since her CD4 count was above 500. However they both remain under medical management and monitoring.

HIV in Solomon Islands is thought to be primarily heterosexually driven, however a limited evidence base inhibits a more robust understanding of risk behaviours amongst certain vulnerable groups. Compared with other Pacific Island Countries and Territories, Solomon Islands has reported a relatively low number of HIV infections. However, while the official HIV prevalence rate is low (2 per 100,000) questions have been raised as to the whether this figure underestimates the true burden of HIV through under-reporting of new cases as a result of gender and socio-cultural barriers to utilising HIV testing and counselling services (such as actual or perceived stigma and discrimination directed towards those found to be HIV positive); a paucity of testing services limiting access; and a weak, poorly representative surveillance system.

Despite the low prevalence of HIV, data consistently show that a high proportion of both women and men are infected with STIs across the country. Limited laboratory testing facilities and poorly trained and resourced health workers in many settings, especially rural areas, make confirmatory diagnosis of specific infections difficult to ascertain, however comprehensive syndromic diagnosis and management of suspected STIs, and a number of surveillance activities¹ provide a strong indicator of this significant contributory risk factor to both STI-related morbidity and HIV transmission. Furthermore, the high prevalence of STIs indicates that certain risk behaviours, such as unprotected sex with multiple partners are widespread, which in turn poses a significant risk for the exponential transmission of HIV.

¹ Solomon Islands Government (2008). Second Generation Surveillance of Antenatal Women and Youth, Solomon Island, Honiara.

The Policy and Programmatic Response

The Human Development Index (0.51) places Solomon Islands 142 out of 187 countries, showing an overall low level of development (based on health, education and income). The Government is the main provider of health services in Solomon Islands and employs 97% of all health workers. The limited availability of skilled health personnel, infrastructure and financial resources, as well as the fact that health services that are not always responsive to the needs of society are a major challenge. Urbanisation in Solomon Islands is 20 percent and increasing at more than twice the overall rate of population growth. Government thus faces the twin challenges of continuing to service largely dispersed and often remote communities while also striving to respond to the pressure of urban growth. It is against this backdrop that disease control programmes have to be implemented. The Government also faces increasing pressures on the budget and revenue with a weak fiscal outlook.

Levels of health care

- (1) Nurse Aid Posts (187) commonly located in remote areas and offer basic primary care, and public health and prevention services.
- (2) Rural Health Clinics (102) offer the next level of care; they play a supervisory role to multiple Nurse Aid Posts within the same area, and arrange outreach activities.
- (3) Area Health Centres (38) provide inpatient, outpatient, outreach and public health-care services to a wider population and act as referral facilities for a number of rural health clinics. Area Health Centres offer specific birthing facilities, as well as administration space and staff housing.
- (4) Provincial Hospitals (8) are often the highest level of care logistically available; particularly to people residing in remote outer islands.
- (5) The National Referral Hospital in Honiara provides the highest level of tertiary care and is staffed by local clinical specialists and also visiting specialists from overseas.

Human resources for health

Solomon Islands is classified as one of 57 countries deemed to have a critical shortage of health workers. There is a significant workforce deficit on every level of care in Solomon Islands, with 0.21 doctors per 1,000 people; 0.11 dentists; 0.11 pharmacists; 1.7 nurses and 0.26 midwives. As well as limited absolute numbers, there is also a heavy bias in workforce distribution with approximately 24 percent of the total health workforce based in the National Referral Hospital, including more than 73 percent of doctors, almost all specialists and 33 percent of nurses. High staff turnover has been a major problem in the Solomon Islands, especially since the ethnic tensions which lasted from 1998 to 2003. Human resource planning, development and management seem very unsystematic and un-coordinated. This highlights the need to produce a comprehensive HR plan which includes all cadres. Currently both pre-service and in-service training are very ad hoc and often driven by international funding rather than skill needs. There are no significant consequences for good or poor performance. While there are SIG-wide disciplinary procedures, these are usually not

implemented unless a staff member commits very serious infractions. Conversely, there is no tangible merit-based reward system, particularly for rewards within current positions.

Essential medicines

As with many other countries in the region, Solomon Islands faces some difficulties in accessing essential medicines. There are no existing drug manufacturers in the country and pharmaceuticals are imported from foreign wholesalers and manufacturers in Australia, New Zealand, Japan, the United States and Singapore. Some medicines transit by Fiji as a regional hub. This affects the health system as a whole and HIV control is part of it.

The availability of essential medicines nationally and provincially has increased dramatically over the past seven years. The availability of 447 essential medicines at the national level has increased from just 47 per cent in 2007 to 93 per cent in 2014. This is double the global average of 46 percent availability for public sector medicine. Availability of critical items at the Stores' 14 provincial medical stores have also more than doubled to 88 percent and 73 percent at the country's 310 rural health clinics.

Health financing

The National Referral Hospital (NRH) receives a big share of the health budget and employs two-thirds of all doctors, despite decentralisation efforts resulting in more equity when it comes to the distribution of other health professional categories. It should also be noted that some of the expenditures for the NRH are for provincial people (e.g. outreach and referrals). As described in other sections, transportation costs for patients are high and may cause financial catastrophe.

Health service delivery

A survey in 2006 found that nearly 87 percent of people sought care when ill (compared to 60-70% in low-income countries in East Asia and the Pacific). Of those who sought care, 85 percent went to a public sector provider and 4 percent to a private sector provider (mostly in Honiara); only 3.5 percent went to traditional healers (*Maike, 2010*). The private sector plays a very minimal role in health. There are four private hospitals, owned and operated through various church organisations. There is a small number of private sector medical clinics in Honiara and some private practice at the NRH and church hospitals.

Various factors combine to prevent or delay a visit to a clinic, including inaccessibility of transport, misdiagnosis, and self-medication. Travel logistics and costs are a major barrier to accessing services given rugged terrain, the large catchment area of some clinics, the high cost of petrol, variable income, unpredictable weather, poor road conditions, among others. Transportation costs are highest for villages that generally rely on outboard motor boats to access clinics. While there is a formalised referral system in place, it is not well adhered to by patients or health-care workers in the provinces, with many people bypassing provincial hospitals and going directly to the NRH for care. This is also due in part to the available transportation routes that make it easier to reach Honiara.

A number of health clinics requires significant upgrade, repair or renovation. The degradation of health facilities has happened over many decades, and while some have been damaged by cyclones and other natural disasters, most are not properly and regularly maintained. Recently

a flooding disaster occurred in Solomon Islands in Honiara and Guadalcanal province (GP) in particular. The flash flood had significant impact on the health systems as well as on the environmental and socio-economic situation, with the loss of livelihoods. Several health facilities in Honiara City Council (HCC) and GP as well as the National Referral Hospital (NRH) at the central level have sustained severe damages. A significant number of health facilities are without water or toilets with little implementation of infection control procedures as there is a significant number of facilities without sterilisers and appropriate medical waste disposal.

Governance, policy and coordination

Most signature authority remains at the central MHMS and most managerial capability remains concentrated in Honiara. Most substantive programmes are planned and managed from Honiara with little or no input from the provinces and many of these programmes' operations in the provinces are carried out with minimal provincial advance coordination – particularly the vertical programmes with major international funding.

Most organisational functions are operated in a very ad hoc manner – the development of systems and good system operation has not been a priority. When a different person takes over the charge of a programme or organisational unit, the programme's or unit's activities and modus operandi may change completely– not being dependent on any past system – unless there is international assistance with a tightly defined work plan. The main system weakness is its capacity to use limited resources efficiently especially a weakness in assessing the full costs and implications of the offer of external support.

The inclusiveness of the stakeholders in the report writing process

This report has been developed with information resources and reports on the national response. The National HIV/STI Coordinator together with the HIV/STI Division team, worked with the Medical Statistics Unit and Provincial Health Departments to collate and validate information for this report.

United Nations Children's Fund (UNICEF), through a long-term HIV/AIDS Consultant, provided direct Technical Assistance to the MHMS throughout the report writing process

II. OVERVIEW OF THE AIDS EPIDEMIC

Since the first case of HIV was reported in the Solomon Islands in 1994, new HIV positive cases have been reported each year although very small in number. The World Health Organization (WHO) has classified HIV as a low prevalence epidemic in most Pacific Island Countries and Territories (PICTs) except Papua New Guinea (WHO 2006). However, it should be recognised that most countries in this region do not have high quality surveillance systems to accurately estimate HIV prevalence. Second Generation Surveillance Surveys conducted in Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu in 2008 reported inadequate knowledge of HIV transmission, unsafe sexual practices, existence of high rates of sex partners and commercial sex in general populations (WHO 2013). UNAIDS has also classified Solomon Islands as a low HIV prevalent country with an estimated prevalence of 0.002% that remained unchanged since 2010 (UNAIDS 2012). It has been reported that 14 out of 22 recorded HIV positive cases are still alive of whom 11 People Living with HIV (PLHIV) are on ART treatment (Theonomi 2013; UNICEF 2013).

In spite of this low HIV prevalence in the country, geographic proximity to PNG may be a potential source of new infections for the Solomon Islands given the large differential in epidemic burden with respect to HIV and other STIs. However, there are scarce data on mobility between the two countries to assess this risk. Data on visitor arrivals collected by the Ministry of Finance suggest that the number of visits from PNG is relatively small—just 9%—but doubled during the period 2008-2011 from 900 to 2000 annually.

Unlike HIV, data regarding STIs in the Pacific Island Countries and Territories (PICTs) were rarely collected. Information are scattered and collected through passive surveillance. Regionally, Syphilis prevalence ranged from 0% (in Samoa) to 10% (in Solomon Islands) in 2005 according to a SGSS (WHO 2006). The prevalence among younger (<25 years) women was much higher (14.8%) than the older (\geq 25 years) women (6%) in Solomon Islands. The survey was repeated in Solomon Islands in 2008. In both surveys, prevalence of STIs including Syphilis (6% among ANC women in 2005 and 2% among ANC women in 2008) were found very high while the prevalence of HIV was reported negligible (WHO 2013). According to SPC surveillance study, Syphilis was found positive among 8% ANC attendees in 2012 (UNICEF 2013).

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Target 1: Reduce sexual transmission of HIV by 50 percent by 2015

1. Prevention of Sexual transmission of HIV

1.1 HIV Testing/VCCT

The current uptake of HIV testing and counselling services is quite low. HIV testing services are provided through HIV testing facilities at the main health centres (client-initiated); as well as through provider-initiated testing and counselling for ANC attendees and TB patients. However, the uptake of HTC services is hampered by a number of factors: poor logistics and supply management resulting in frequent stock-outs of rapid test kits; lack of systematic promotion of HIV testing; insufficient capacity of health-care staff; and inadequate HIV test facilities in selected locations (e.g. lack of confidentiality).

The prioritisation of the use of HIV test kits for blood screening leads to structural stockouts of test kits for VCCT and ANC clients. In 2015, despite the consistent availability of testkits from April to December, only 3263 HIV tests were conducted across the country (by reporting time, this was the data available at HMIS; pending updates from the provincial health departments and hospitals). Also, out of a total 18,406 first ANC visits, only 2835 were tested for HIV.

The low number of people tested hampers the effective detection of HIV cases. To date (December 2015), only 28 HIV cases have been detected, of whom 12 are still alive and 10 on ARV treatment. Late diagnosis of HIV hampers successful enrolment in ART and may lead to avoidable AIDS deaths. Hence, increased uptake of HIV testing services is a major priority for Solomon Islands.

1.2 Condom promotion and distribution

Several studies report low condom use among any population: results from a surveillance study among ANC women show that more than 10 percent had never heard of male condoms, while almost half (47%) had never heard of female condoms. Only half (53%) had ever used a condom, and 63 percent never used a condom in the past 12 months. The same study also included male and female young people, which showed higher condom use: 32 percent of males and 26 percent of females had used a condom at last sex. However, 38 and 42 percent of males and females respectively had never used a condom in the past 12 months. Most important reasons given for not using a condom included 'not easily available' (38%) and 'less pleasure' (21%) (MHMS, 2008).

The 2009 UNICEF study which included adolescents and young people from different risk backgrounds reported condom use at last sex by 37.3 percent of all respondents, with higher percentages among males (42.3%) than among females (33.1%) UNICEF 2010. The study revealed interesting differences in condom use at last sex for different subgroups: especially vulnerable adolescents (54.5%), most-at-risk young people (48.8%) and adolescents (38.6%) used condoms more frequently than mainstream youth (33.8%), possibly reflecting greater sexual experience and skills. Condom use at last sex was also considerably higher among

males (42.3%) than females (33.1%), possibly due to less negotiating power of girls with older sex partners. Age was another important factor, as condom use was considerably higher among young people (20-24 years) (46.8%) than among adolescents (15-19 years) (31.1%) *UNICEF 2010*.

1.3 Programmes for Mobile Populations / Seafarers

In Solomon Islands, Church of Malenisea has been working with seafarers but mainly dealing with health education and spiritual talks as FBOs normally do not promote condoms. However, data on the number of people reached by this organization was not available at the time of compiling this report. The seafarers also have a clinic at the logging port where they access HIV services such as condoms distributed by the MHMS.

1.4 Blood Transfusion

In Solomon Islands, blood donation mainly takes place at the NRH where blood donated is tested for HIV through RDT, syphilis / STIs and Hepatitis. However, the practice is that if any blood donor turned out positive or reactive for any of the above tests, their blood is not drawn for donation but they are referred to the appropriate clinic for care and treatment.

1.5 Programmes for Men who have Sex with Men

In Solomon Islands homosexuality men who have sex with men are little accepted, if not (culturally, morally and religiously) rejected. In addition, sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. MSM and transgenders are particularly hard-to-reach populations, as the majority will avoid seeking any specific services targeting MSM, for fear of being identified as “homosexual” by their families or the community. This is further compounded by self-stigma and low self-esteem among many MSM.

While some interventions were implemented for MSM in the past with support from the Response Fund, specific services targeting MSM are very limited, with only NGO still working with a very small number of MSM. In the virtual absence of MSM-specific programmes, very few are reached with HIV/STI-prevention services, including HIV testing. These low HIV-testing coverage rates may hamper early detection and timely access of MSM to ART, as well as treatment-as-prevention (TAsP) approaches. Compounding the self-stigma among MSM, *negative attitudes towards MSM in the health-care sector* may further hamper their access to health services such as STI treatment and HIV testing, as MSM may avoid these services due to negative staff attitudes. In addition, non-acceptance by society may lead to low self-esteem among young MSM, which can lead to unhealthy behaviours associated with low control of sexual risks.

While several studies have looked into HIV, STIs and risk behaviours among ANC women or young people, very little research has been done among men who have sex with men (MSM). In the 2008 survey among young people, 0.8 percent of males (15-24 years) in Honiara reported sex with another man in the past 12 months (*MHMS, 2008*). The UNICEF study among different types of youth in 2009 found only 5 respondents out of 233 (2.1%) reporting sex with men in the past 12 months (*UNICEF, 2010*). These percentages are not statistically significant, and may represent an under-estimate of the true proportion of MSM: homosexual

acts are illegal in Solomon Islands, and there is strong societal stigma towards MSM, which may result in reluctance to report MSM behaviour in studies. As mentioned above, in the 2008 study among youth, 25 percent of males reported ever being forced to have sex, including by male perpetrators (*MHMS, 2008*). This may indicate that more men than commonly thought seek MSM sex, and may find it easier to force young men or boys into sex. Some programmes for MSM have been implemented in the last few years, but no HIV-related data has been collected and there is no documented evidence about their sexual risk behaviours.

1.6 Programmes for Sex Workers and their clients

commercial sex work as seen in other parts of the world – e.g. brothels, street-based sex work, pimps – is much less present in Solomon Islands: few women engaging in sex work will self-identify as “sex workers”. Rather, women and girls engage in transactional sex, providing sexual services in exchange for money, goods, food and alcohol, or other types of in-kind compensation. While unemployment and economic problems may be the main reason for engaging in transactional sex, girls and young women may also engage in sex in exchange for luxury goods or free entertainment. While HIV-prevention programmes for sex workers were supported in the recent past by the Response Fund, and some of those activities continue at a small scale in Honiara, few specifically target the many young women and girls engaging in transactional sex. Furthermore, *criminalisation* of sex work hampers the availability and accessibility of these programmes. Both selling sex as well as owning a brothel or “aiding or abetting” prostitution for personal gain are illegal under Section 153 and 155 of the Solomon Islands Penal Code. The current legal ground creates challenges for accessing sex workers for prevention and surveillance purposes. High STI rates among young women (and men) and among antenatal women, as well as high teenage-pregnancy rates reveal the widespread underlying risk behaviours of these women and girls.

In addition, existing reproductive and sexual health services – including HIV testing – predominantly target pregnant (often married) women. Access to reproductive health, STI treatment and HIV-testing services is much more limited for *young* women and men: While there is a limited number of *youth-friendly clinics*, mainly in the main towns of the different provinces, in most other locations young people may feel uncomfortable accessing SRH services in small island spaces, or be denied access to certain services altogether due to their young age. Hence, future programmes need to be better tailored to the needs of these young women and girls engaging in transactional sex, and their clients.

Several studies reveal that transactional sex and sex work are relatively common among young people. In the 2008 survey among young people, 13 percent of males and 9 percent of females had engaged in transactional sex, receiving goods or favours for sex (*MHMS, 2008*). In the bio-behavioural survey among ANC women in 2015, 2.1 percent of women reported they had received money or gifts in exchange for sex in the past 12 months (*MHMS, 2015b*),

The UNICEF study in 2009 (*UNICEF, 2010*) among youth with different risk patterns – mainstream, most-at-risk and especially vulnerable – revealed that 12.4 percent of the total study population had had *sex for money*: almost one-fifth (18.7%) of females and 6.5 percent of males. Young people (20-24 years) engaged more in sex for money (15.1%) than adolescents (15-19 years) (10.1%). Commercial sex was much higher among youth in Honiara (23.3%) than in other provinces. A considerable proportion of youth also engaged in *transactional sex* – sex for gifts, goods or favours: 10.7 percent of the total population, with females 16.5 and males 5.2 percent. Alarmingly, two-thirds (66.1%) of those engaging in

transactional sex had *not* used a condom at last sex (*UNICEF, 2010*). *Reasons given for engaging in transactional sex* included ‘need money’ (60%), ‘was forced’ (11%), ‘need food’ (7.9%) and ‘need drugs or alcohol’ (3.2%) (*UNICEF, 2010*).

1.7 Programmes for transgender people

At the moment there is no evidence indicating the existence of transgender people in the Solomon Islands.

1.8 Programmes for children and adolescents

A 2010 UNICEF and MHMS study on HIV and AIDS risk and vulnerability among young people in three provinces plus Honiara found that 67% of sexually active youth were having unprotected high risk sex, and 15% of all 15-19 year olds had sex before the age of 15. First sex was forced for 20% of the sexually active youth overall, and in Choiseul it was over 45%. The study found low use of reproductive and sexual health services among young people, who explained this on the grounds that services were not available, not accessible and not youth friendly. Both boys (25%) and girls (20%) reported high rates of STIs in the past year.

Teenage pregnancies are common in the country. DHS (2007) found that by the age of 19, one in four teenage girls have become mothers with consequent impacts on their educational and economic prospects and those of their baby; children of teenage mothers tend to have poorer health and education outcomes. The median age of marriage was found to be 20.3 years for women. Teenage pregnancy is more common in rural than urban areas and among women with only a primary education. The DHS also found that rates of teenage pregnancy are higher in Guadalcanal than other regions. Use of contraception by young people is reportedly very low at 2% for 10-24 year olds. Up to date evidence on young people’s sexual attitudes, knowledge and practices is urgently needed to support reproductive and sexual health programming for young people. Primary health care facilities continue to have a strong focus on pregnant women and children; and access of young people and men, and especially vulnerable groups such as men that have sex with men is inhibited. There are four youth friendly clinics in the country – a start, but insufficient to meet needs given lack of young people’s access to alternative sources of reproductive and sexual health information and clinical services and products.

In Kukum Clinic and Lata Hospital, the facilities have created a room towards the back of the building as an adolescent health area but to reach the room a young person would have to walk past the many women and children lined up waiting to see a practitioner. The staff appreciate that this deters young people who are fearful of being recognised at the clinic by someone in their community. Increasing young people’s access to reproductive and sexual health care will require a number of important changes around service delivery, nursing attitudes and skills, and service protocols. Nurses and nurse aides will need orientation on government policies towards young people’s sexual health, and awareness of the risks that poor sexual health carries. Nurse counselling skills need to be strengthened so they are better able to counsel young people, and protocols updated and revised to guide the delivery of

reproductive and sexual health services in line with policy, including contraception and treatment of incomplete abortion.

1.9 Community mobilization

Community participation is fundamental to the principles of primary health care, and women's empowerment is a social determinant of health. International experience shows that community leadership, support and commitment is vital to improving health and tackling behaviours that undermine well-being. Important influencers of health in the Solomon Islands are the community structures that bind people together and hold authority. This includes traditional elder structures, as well as various church organisations and youth groups that have the communication structures and clout to influence attitudes and practices.

Community and traditional authority structures including the church have proved to have considerable influence over health seeking and access to care. Some churches inhibit discussion of reproductive health and sexuality and set strict norms for what is acceptable sexual behaviour, with obvious implications for family planning and safe sex. Cultural norms and attitudes apply to health workers too, and affect health protocols. Current maternal health guidelines restrict the provision of contraceptives to married persons, and from interactions with nurses during the 2014 GESI study, it was established that this protocol was still being practiced, with the exception of condoms. Attitudes among health staff towards the morning-after pill and abortion are also very sensitive. Nurses need information on new government policies, training, and up to date protocols aligned with government policy.

There are no formal functioning mechanisms for community participation in the delivery or management of health services in the Solomon Islands, although there is provision for Health Boards. There are few examples of citizen led social accountability with most advocacy being driven by Civil Society Organisations. Participatory planning is not well established in government, and in 2014, efforts by the RWASH program to involve communities in the planning of water systems struggled to negotiate space for women.

Church organisations and groups, village elders, and youth groups are seen by health workers and managers to be key vehicles for promoting demand for services and behaviour change. The involvement of community based structures and organisations is central to mobilising support for increased access to health services, addressing issues related to gender equity, gender based violence and social inclusion. The existing relationships between non-state actors and communities to address the determinants of health and increase access to services, provide government with a platform to strengthen its partnerships with communities for more equitable and inclusive health.

1.10 STI diagnosis and treatment

While HIV rates are very low, very high STI rates in Solomon Islands reveal that the underlying behavioural risks are high, with a real potential for a future increase in HIV cases.

Table (2) shows the results from routine testing in ANC services in 2014, which reveal very high rates of syphilis: the overall rate is 13.5 percent, with particularly high rates of 30.6 percent in Western Province; and higher rates among the 15-24 year old group than in the 25+ group (15.8% vs. 11.8%).

Table 2: *Number of ANC mothers tested and treated for syphilis in Solomon Islands in 2014*

SYPHILIS TESTING IN ANC, 2014 (MHMS, HIV/STI Unit)									
PROVINCE	TOTAL TESTED			TOTAL POSITIVE					
	TOTAL	15-24	25+	TOTAL		15-24		25+	
HONIARA	5824	2488	3328	795	13,7%	415	16,7%	378	11,4%
WESTERN	629	262	367	86	13,7%	35	13,4%	51	13,9%
MALAITA	732	283	447	103	14,1%	54	19,1%	49	11,0%
CHOISEUL	271	119	152	1	0,4%	1	0,8%	0	0,0%
MALAITA	220	103	117	26	11,8%	12	11,7%	14	12,0%
WESTERN	330	160	170	101	30,6%	38	23,8%	63	37,1%
MAKIRA	316	134	180	15	4,7%	7	5,2%	8	4,4%
TEMOTU	0	0	0	0		0		0	
TOTAL	8322	3549	4761	1127	13,5%	562	15,8%	563	11,8%

A study among young people in 2008 found high rates of chlamydia (males 10%; females 18%) and lower rates of gonorrhoea (males 4%; females 2%). Table (3) shows the findings from the same study, but among ANC women: high rates of hepatitis B (14%) and chlamydia (11%) (MHMS, 2008).

Table 3: *STIs Prevalence among Antenatal Women, Solomon Islands, 2008 (MHMS, 2008)*

Prevalence of STIs, Antenatal women, Solomon Islands 2008			
	Tested	Positive	Prevalence
Trichomonas	189	34	17%
Hepatitis B	298	41	14%
Chlamydia	371	40	11%
Syphilis	296	10	3%
Gonorrhoea	371	5	1.3%
HIV	298	0	

1.11 Behaviour change programmes

The high STI rates in Solomon Islands reveal underlying high-risk sexual behaviours, which have been confirmed by several behavioural studies among ANC women and youth. A study among youth in 2008 found that 16 percent of females and 19 percent of males had had *their first sexual contact before 15* (MHMS, 2008). Similar results were found in a study by UNICEF among mainstream and most-at-risk young people in 2009: 15 percent of all youth had first sex before 15; in Honiara this was considerably higher at 28.8 percent. The results revealed big differences in first sex before 15 between most-at-risk adolescents (52.4%); especially vulnerable adolescents (25%) and mainstream youth (4.5%), which shows the importance of differentiating between higher and lower risk youth for interventions (UNICEF, 2010).

In the 2008 study among youth, more than half (52%) of the males and one-third (33%) of females had had *more than one sex partner in the last 12 months*, with an average number of partners of 3.8 for males and 2.6 for females (MHMS, 2008). Furthermore, more than half (56%) of males and 41 percent of females had *concurrent sexual relationships* (MHMS, 2008).

Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

2. Prevention of mother-to-child transmission

2.1 ARVs for PMTCT

To-date, five children have been born to women living with HIV in the country out of which one of the children was not tested before death, one was not tested at birth or in the first 18 months but later tested HIV positive at 13 years in 2014. The other three were tested at birth and follow up testing was done at 24 months, and both tests were negative for HIV among all three cases. For all the cases no ARV syrap or PMTCT related medication was given to the children, but the mothers were on treatment and did not breastfeed.

A total of 2,835 out of 18,406 pregnant women were tested for HIV in 2015. There were no HIV positive among the tested women. Also, none of the 10 women currently living with HIV became pregnant during this reporting period.

2.2 Non-ARV-related component of PMTCT

During the SGSS 2015 among antenatal women, about 31.5% women reported to use any condom in the last year. Most of them were older women (33.8%). A high proportion of pregnancy among recent condom users may be a reflection of irregular use of condoms or condom-failure in preventing pregnancies. When asked regarding the use of condoms during the 1st time having sex, about 18.5% women reported that they used condoms. No significant difference in condom use by age group was found. About 3.4% women who had multiple sex partners reported to use condom at the last time having sex. Low use of condoms was also reported in a 2007 survey that showed that only 14% of women aged 15–24 used a condom at the first time they had sex (NSO 2007). Pregnancy among women who reported to use

condoms by their partners every time indicated inappropriate use of condoms during sex. The proportion of occasional users was reported 28.9% and more than two-third (68.3%) women never used condoms. None of the teenage antenatal women reported to 'every time' use of condoms to prevent pregnancy in the past year. About 79.6% of them never used condoms during this period.

Also during this survey, an attempt was made to understand the willingness of taking HIV tests and PMTCT services as perceived by the antenatal women. The study revealed that nearly 99.2% of the antenatal women were willing to take an HIV test if offered in convenient locations. About 94.1% antenatal women would be willing to access PMTCT services if needed. Those who were not ready to access the PMTCT services had provided reasons for not using them even if they were found infected with HIV. About 1.5% did not want to disclose their HIV status to their husbands, partners or neighbours while 1.2% found receiving PMTCT services as shameful or embarrassing. A small proportion of women expressed their desire to become a mother again.

Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

3. Universal access to treatment

3.1 Pre-ART care and palliative care

The Solomon Islands government is committed to providing free treatment, care and support to all HIV patients, and will support ARV drugs for all eligible patients from government budgets. The current policy is to enroll patients in ART if their CD4 count is below 500 (from 350 previously); as well as all patients with TB or Hepatitis B coinfection; and pregnant mothers. Three health facilities in the Solomon Islands offer ART. Two are based at provincial health facilities and the National Referral Hospital serves as the third. There are currently 10 people living with HIV currently enrolled on ART (2 male and 8 female), and an additional two (both female) who are not on ART but are under clinical monitoring. One patient lives on Temotu island, which has no ART services to date.

3.2 Adult antiretroviral treatment

Solomon Islands is currently implementing the World Health Organizations (WHO) Antiretroviral Therapy for HIV Infection in Adults and Adolescents (2015) as its eligibility and treatment guideline. Three health facilities in the Solomon Islands offer ART. Two are based at provincial health facilities and the National Referral Hospital serves as the third.

In 2015, ten existing PLHIV and three new cases were enrolled on ART. With support from UNICEF, routine treatment monitoring through CD4 testing will be rolled out in 2016 and this will be done every 6 months for all patients. The GenXpert viral load test is easy to use with limited requirements for training of laboratory staff. The rapid availability of VL test results will help support better clinical decisions and enable timely adjustments to appropriate

ARV therapy, which will help avoid drug resistance. With increased HIV testing in place, it is expected that a maximum of 5 new patients will be enrolled on ART each year.

3.3 Paediatric antiretroviral treatment

At the moment, only one of the children born to HIV positive mothers has tested HIV positive, and this diagnosis was done in 2014 when the child was 13 years. There are other four children currently aged between 5 and 6 years who were also born to HIV positive mothers, were tested at birth using determine tests, and follow-up tests were done at 24 months instead of 18 months, though according to the core care team members interviewed reported that both tests at birth and 24 months were negative for all 4. During this time none of these children were taking any HIV related medication but their mothers were on ART for PMTCT. This gap in PMTCT is highly attributable to the outdated PMTCT guidelines being used in the country, which were only developed a few years back. The guidelines are not in line with the Option B+ strategy and do not match the recommended WHO 2013 consolidated guidelines.

3.4 Support and retention

The HIV core care team is charged with following up, counselling and linking all PLHIV to care and treatment. The team maintains a maximum level of confidentiality in handling these clients and at all times limits the identity of all PLHIV to team members only to prevent stigma and discrimination of PLHIV, and promote adherence to care and treatment.

Target 5: Reduce tuberculosis (TB) deaths in people living with HIV by 50 percent by 2015 TB

4. TB-HIV Co-infection

Historically, there has been few programmatic links between the Solomon Islands National TB Programme and the HIV response. In 2010, TB treatment and management guidelines were formally reviewed and updated to include HIV/TB co-management, and in 2011, 12 TB nurses and coordinators throughout the country were trained to do HIV counseling and testing. Since then, have been programmatic links between the NTLP and the HIV programs. TB/HIV collaborative activities were introduced in the TB manual updated in 2012 while the HIV programme staff were involved in the development of the TB NSP, which includes HIV in its situation analysis and its strategies. The same was true for the new HIV NSP in whose development the NTLP programme manager was involved while the National ART guideline has a special chapter devoted to TB/HIV collaborative activities.

TB staff have been trained on PITC and HIV testing has started to be routinely offered to TB patients in 2010 and PLWH are screened for TB whenever they come to pick up their ARVs from the HIV programme although this is not performed on a systematic way. The TB recording and reporting system was revised in 2013 to capture all information needed to monitor collaborative TB/HIV activities from the TB programme side. So far on record, only one patient has presented with a TB/HIV co-infection and this was in 2014 where the patient was admitted to the Medical ward and was tested HIV reactive through PITC. In this case the

HIV core care team decided that the patient first completes the TB treatment for 2 months before being initiated on ART. This patient later died because it was a late diagnosis in WHO Clinical Stage four where the patient had presented with advanced an Opportunistic Infection (OI).

In 2014 the country continued strengthening TB control by introducing a new rapid diagnostic technology, the GeneXpert test, which is considered an important breakthrough in the fight against TB. Moreover, it allows to quickly diagnose rifampicin resistance prompting early treatment, which is of great benefit for people living with HIV as MDR TB carries higher risk of mortality in this population. HIV-positive presumptive TB cases are highlighted in the revised TB diagnosis algorithm. This technology will be particularly useful in the diagnosis of TB among people living with HIV as TB forms in this population are more frequently negative at smear microscopy. The GeneXpert machine of the TB programme is also being used for Viral Load testing of HIV patients through the use of HIV Viral Load and EID cartridges under the national HIV programme, as part of the TB/HIV programme collaboration.

To this end the TB programme will make use of enhanced existing technologies, tools and approaches as well as new ones using among others modern technologies including new rapid diagnostic tests, SMS notification of lab results and electronic recording, reporting and follow up of TB patients. Specifically, the NTP has planned the following actions to counter the TB/HIV co-infection component:

- Establish screening of all people living with HIV for TB at every contact within the HIV clinic
- Put all people living with HIV on Isoniazid Preventive Therapy after ruling out a TB disease
- Establish sentinel surveillance of HIV among TB patients, pregnant women and blood donors.
- Test TB patients for HIV and put any TB/HIV co-infected patient on CPT and ART

In order to implement, monitor, evaluate and accordingly revise the TB/HIV collaborative activities planned in the National Strategic Plans of both TB and HIV programs, the following actions will be taken in order to achieve further alignment of the TB and HIV strategies, policies and interventions at different levels of the health system and community structures:

- Establishment of a national TB/HIV working group composed of representatives from the two programs, key populations, civil society and international partners involved in the TB and HIV responses. The group will have monthly meetings to fulfill its functions described above.
- Development of an annual TB/HIV operational plan derived from the two respective national strategic plans and the present GF grant.
- Development of TB/HIV monitoring report to be filled by the TB/HIV working group. While the information captured in this report is supposed to be already captured by the respective disease recording and reporting systems, this report will serve to foster the collection of TB/HIV data by both programs given the universal weakness in the collection of these data.
- Establishment of a surveillance system to assess the prevalence of HIV among TB patients
- Certification of all TB sites to conduct HIV testing services, to ensure 100% testing of all TB patients for HIV, and vice versa.

- Optimise the involvement of NGOs already dealing with HIV in TB control by mapping them and establishing a dialogue between them and the two programs
- Development of a strategic framework of collaborative TB/HIV activities stated below:
 - a) The collaborative activities between the two programs
 - b) The role of the HIV programme in reducing the burden of TB among PLHIV and of the TB programme in reducing the burden of HIV among patients with presumptive and diagnosed TB
 - c) Referral system between the two programs
 - d) Monitoring and evaluation of TB/HIV collaborative activities
 - e) The different actors involved in addressing the TB/HIV problem
 - f) Decentralisation and integration of TB/HIV services

4.1 TB screening and diagnostics for PLHIV

Available evidence indicates that Solomon Islands has a low prevalence rate of HIV among TB patients. Prior to 2010, TB patients were not routinely tested for HIV infection. In 2014, out of a total of 344 TB cases throughout the year, 45 were tested for HIV and one of them was found HIV positive through PITC but this was a late diagnosis hence the patient died.

4.2 TB treatment for PLHIV

So far on record, only one patient presented with a TB/HIV co-infection in 2015 where the patient was admitted to the TB ward and was tested HIV reactive through PITC after the TB the patient had been non responsive to the TB treatment.

This patient later died because it was a late diagnosis in WHO Clinical Stage four where the patient had acute meningitis which had affected the brain.

Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22-24 billion in low- and middle-income countries

5. Governance and Sustainability

5.1 Strategic information

The health information system is under development and many improvements have been made over the past couple of years including the preparation of annual statistical reports disaggregated by province and facility, and the preparation of the “Core Indicators Report”. The latter benchmarks progress made against the National Health Strategic Plan that is the policy platform of the Sector Wide Approach (SWAp). However, gaps remain in reporting with estimates of 60% and 85% of reports being submitted in 2011 and 2012. Gaps in administrative staff at busy facilities, such as NRH, hinder reporting, and innovative ways of engaging volunteers or interns for example, could be a way to address this.

Evidence gaps have also arisen due to the long time lag between DHS; the last was in 2007 and the next was due in 2014 but this was not conducted. No health focused household sample survey of a similar breadth and rigour has been undertaken in-between. Similarly there has been a long gap between household income and expenditure surveys, 2005/6 being the last one; and the next was due 2014. The result has been a long period without accurate disaggregated evidence of key health outcomes and behaviours. The planned DFAT funded poverty and health outcome study and UNICEF funded Second Generation Sentinel Surveillance (SGSS) study for HIV and STIs will be important sources of evidence for identifying health vulnerability, as will the Monash University costing study which includes measurement of out of pocket spending on health. All three studies will be important to inform stronger pro-poor and inclusive programming.

The data that is being collected by facilities is reported up to provincial and national levels but is often not used at the local level for provincial and facility based planning and monitoring. In turn there is a lack of geographic and context specific planning and this is an area that the Director of Reproductive Health intends to strengthen. The Family Health Card, which is kept at the facility, is reportedly being completed well in some provinces but not universally; though use of the data at provincial or facility level is weak. Further analysis is needed to find out how collection and use of this data could be improved.

There is a legal requirement to report all births and deaths in the Solomon Islands, but the system is out-dated, time consuming and costly as it requires the reporting person to visit Honiara. With support from UNICEF, the birth and death registration system became electronic in December 2012 but the Ministry of Home Affairs has not been able to devolve this responsibility to provinces and hence people still have to travel to Honiara.

Looking forward, the MHMS plans to decentralise the health information system in the three most populous provinces namely Guadalcanal, Malaita and Western; and to provide parallel management strengthening support through the Health Sector Support Program (HSSP). This will provide a platform to improve provincial and facility planning, monitoring and management.

5.2 Planning and coordination

The Solomon Islands Government spends more than 10% of its domestic budget on the health sector and this is not expected to grow in the medium term. The 2013 independent performance assessment of the Health Sector Support Program (SWAp) found that 36.4% of the 2013 sector budget allocation was allocated to the provinces; increasing the share of provincial grants is one of the objectives of HSSP. Provincial budgets are used to hire direct wage employees and fund outreach and supervision activities, which are essential for increasing access to services. Budget constraints at the provincial level are commonly reported to result in cancelled outreach and supervision, and inhibit access to services of those living in remote and difficult to reach areas.

In 2014, the Annual Operational Planning (AOP) and budgeting process improved with some divisions submitting fully costed plans for 2014. Planning guidelines are prepared but have yet to introduce gender issues and guidance. Divisions tend to develop their AOPs in isolation and more work is needed to strengthen the synergy and coordination between them, with for example cross-cutting areas like health promotion more integrated into achieving the objectives of technical divisions and programs; and common approaches taken to meeting the needs of underserved populations that may be geographically and/or socially marginalised such as adolescents.

Provincial level planning and management capacity is generally considered to be poor. Geographic and context specific service delivery planning is not happening although there is considerable diversity in access to services between and within provinces, let alone in meeting the needs of particularly vulnerable populations such as youth, the very remote, and the culturally different, such as Kiribati populations.

5.3 Procurement and logistics

5.3.1 MHMS Procurement System

The National Medical Stores (NMS) does procurement of drugs for the country. NMS then distributes to Pharmacies in Provincial Health Centres from where the drugs are distributed to the Rural Health Clinics and Nurse Aide Posts. The MHMS Policy and Planning Unit has the Ministry's head of procurement.

The MHMS has no procurement plan or matrix in place, and data management for procurement and supplies is poor. There are steps being taken under the Global Fund Malaria Program to conduct HSS including in the area of procurement where the programme will fund a procurement position and develop procurement tools and guidelines such as a procurement matrix and plan.

5.3.2 Supplies and Supply Chain Management

MDG 8 has a number of indicators, and one of them relates to health – “proportion of the population which has access to affordable essential drugs on a sustainable basis.” The 2003 HDR reported that this essential drug “access” varied from 80 to 94% throughout the Solomon Islands. This was at the time when the civil disturbance was just ending. There is no global proposal for the quantum or percentage of change for this indicator and MDG goal, but the modality of the MHMS operation with essential drugs available free of charge at all service delivery points makes it axiomatic that the public's sustainable and affordable (free) access to these drugs is only a matter of the public's access to services. It could be argued that the MHMS service delivery network could be expanded further so that access was easier for more of the population. However, countries that have done this at this stage in the demographic and epidemiological transitions have often found that these new peripheral service facilities get by-passed almost as soon as they are constructed. Therefore, this issue of access is more of a function of transport infrastructure and transport cost than the public

being disenfranchised by cost or other access factors. Therefore, for the Solomon Islands this MDG can be considered achieved.

In recent years however, attributable to the increasing uptake of health services in the facilities, stock-outs have been frequently reported. In 2014, stock outs were reported by several stakeholder groups to remain a problem, though it was generally felt that the situation was better than the previous year(s). During visits to facilities in Honiara, health workers reported stock outs of cord clamps at NRH, and chloroquine at Kukum Health Centre. Stockouts of HIV and STI test kits and supplies were also reported as a major challenge for HIV testing especially in the provinces. Some participants in past health studies reported that stock-outs and absent health providers were two factors that discouraged them from attending health facilities.

The essential drug list supports the SI Government to prioritise cost-effective interventions, and affordable medicines. Challenges to those principles are however being voiced as elite groups lobby to include expensive medicines for minority conditions. MHMS will need to remain firm in protecting the fundamental principles of the essential drug list so that it is not hijacked by elite interests.

5.4 Health Systems Strengthening

5.4.1 Health System

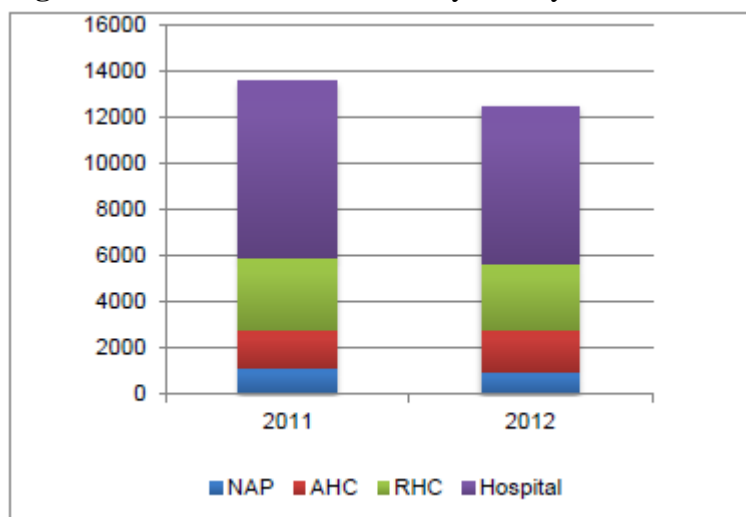
The health system has achieved impressive results. The nurse led Primary Health Care (PHC) system, run at a modest cost of the equivalent of US\$150 per person, has achieved high service utilisation across all income groups as found in the 2007 DHS. This is especially remarkable given the geographical context and scattered population. Other countries are spending much more (in the order of US\$400) to achieve similar health results. In 2006, a survey found that nearly 87% of people sought care when ill, with the majority (85%) attending a public sector provider. By comparison, only 60-75% of the population seek care when ill from a modern medical provider in many low-income countries in East Asia and the Pacific. However, the Solomon Islands faces many of the same health sector strains of other Pacific Island countries as discussed in this section of the report. This includes a weak fiscal outlook, gaps in and aging of human resources, and the double burdens of maternal, newborn and communicable disease and burgeoning NCDs, alongside high child under-nutrition and adult obesity.

5.4.2 Health Facility Coverage

MHMS data on the place of delivery by facility type for 2011 and 2012 shows that more than 50 per cent of institutional deliveries take place at a hospital.

See figure below for deliveries taking place at facilities between 2011 and 2012, to give an indication of the demand for health facilities in the country.

Figure 6: Institutional deliveries by facility level, 2011 and 2012



This reflects a strong demand for health facilities for different services including ANC and hospital level delivery and care, given the geographical spread and isolation of the population. In 2011, 40% of all institutional deliveries took place in Honiara alone, dropping to 36 per cent in 2012, though Honiara makes up only 12.5% of the national population. On cost-efficiency and equity grounds one would expect to see the proportion of women delivering in Honiara further decline as the capacity to handle complications in provincial facilities improves, and public confidence in local delivery care increases. For example, during the 2014 GESI study, the Director Planning reported that many women travel from Malaita and outlying islands to deliver in Honiara because they perceive the care to be of better quality. Similarly, women interviewed at Helena Goldie hospital reported their preference to deliver at the hospital rather than closer primary health care facilities because of perceived quality of care.

The Role Delineation Policy (RDP) that was approved in 2014 by the Health Minister sets the norms for the organisation and staffing of the health sector, and the parameters for future expansion of the health network. It also provides the basis for defining the essential packages of care. As such, the role delineation policy has important implications for ensuring equitable access to services and reaching underserved groups, and potentially for defining remote area packages of care. While expansion of the health facility network is not planned for the next three years, implementation of the policy will require the physical mapping of facilities and populations and topography. This exercise will enable MHMS, community representatives and citizens to assess the gaps in the current spread of health facilities and identify where new facilities are needed. Stakeholder buy-in to the RDP will be essential to bring political, church and community groups on board to avoid the building of ad-hoc clinics.

5.4.3 Human Resources for Health (HRH)

Government is the main provider of health services in the country and employs 97% of the country's health professionals. In 2013, Solomon Islands Government (SIG) employed 1,827 health workers of which 5.9% were doctors, 44.3% nurses and 5.9% nurse aides. With 1.71

health workers (doctors, nurses and midwives) per 1,000 population, this is well below the WHO minimum threshold of 2.3 workers per 1,000 population. Women make up 66.6% of the nurses and nurse aides but only 20.6% of doctors. All executive positions in MHMS are held by men, as are all nurse leadership positions. Male dominated leadership cuts across Solomon Islands political, cultural and religious domains.

The uneven distribution of health workers across the country impacts on access to services and quality of care. Skilled health workers are concentrated in Honiara where only 12.5% of the country's population lives, and continuing migration of health workers to Honiara is likely to deepen the imbalance. In 2013, the doctor: population ratio was 1:1,319 in Honiara and 1:18,929 in rural areas; the nurse: population ratio was 1:305 in Honiara and 1:885 in rural areas.

Human resources are also inequitably distributed across the provinces. The concentration of medical and specialist health staff in Honiara fuels high referral costs for the health system as well as adding strain on family incomes as people have to cover time away from their livelihoods, and living expenses while in Honiara. It also encourages by-passing of primary health care facilities, increasing the cost to the system of delivering primary level care, as well as the out of pocket spending users make on services that could be provided closer to home.

The Government's commitment to free health services, while a laudable equity principle, does not incentivise care seeking at lower levels of the service delivery chain and as demands for hospital level care increase this may put further pressure on the National Referral Hospital (NRH). Renbel with 0.6% of the national population has no provincial hospital, but nearly ten times the number of referrals to NRH than other provinces (Negin, 2011).

Poor working conditions, lack of or poor quality accommodation, and lack of school opportunities for children in rural areas increasingly discourage staff from taking rural and remote postings as expectations rise. Unattractive remuneration packages and limited support provided to health workers further add to the low morale reported. Absenteeism and the difficulty in retaining staff in rural areas has been recognised by all stakeholder groups; leaving some areas underserved. Weak supervision throughout the health system partly linked to high transport costs, lack of funding and low prioritisation, contributes to the problem of absenteeism. Nurses at Kukum Health Clinic in Honiara, during the 2014 GESI study, reported high workloads, limited support, and few promotion prospects. They also felt that the Nursing Council was not an effective advocate for nursing in the country, and provided no tangible benefits to those registered.

Due to a lack of skills and equipment in-country some HIV&AIDS related testing has to be sent out to Fiji and Australia. This is costly and time-consuming. In 2013, Kukum clinic in Honiara sent a sample for gonorrhoea testing to Fiji in January and the results were returned in October after a baby was born with an eye infection; the mother was positive. It was confirmed that test results were delayed that year because MHMS held outstanding bills.

Also according to the 2014 GESI study, a major HRH issue that the country is facing that could distort resourcing is the imminent return of 100 Cuban trained doctors. While the new stock of doctors will help fill gaps in the country the large allowances they are entitled to will significantly raise the salary budget. This is at a time when a government employment freeze has left graduating nurses without jobs and as the numbers of retiring nurses is expected to increase. The impact of these challenging HRH decisions carries a strong weight, especially as urban elites and influential members of society are demanding higher level services that are at odds with the PHC focus of the health system.

Going forward, posting and retaining health workers in rural and remote areas will be key to assuring access to health services. This will require carefully crafted strategies to motivate and support nurses in rural and remote settings. This may include financial allowances, aligning nurse promotion prospects and training opportunities with time spent in rural facilities, improved clinic environments and better supportive supervision. Further work possibly linked to the implementation of the Rural Development Policy is needed to assess what is needed to retain and motivate rural nurses.

Target 7: Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

6. HIV Related GBV Activities

Apart from risk behaviours where partners have a level of control over condom use and other protection, *forced sex* leaves no room for protection, and therefore constitutes a key risk for HIV transmission, as well as other sexual and reproductive health problems, including unwanted pregnancy and psychological trauma. Studies on transactional sex reveal that part of this is forced sex (see above) (UNICEF, 2010).

Gender-based violence is a cross-cutting theme in most studies on HIV, STIs or reproductive health in the Solomon Islands. In the most recent survey among ANC women in 2015, 15.6 percent reported physical or sexual violence from male intimate partners in the past 12 months, with 6.3 percent reporting forced sex (past 12 months), while 12.3 percent reported 'ever forced sex' (MHMS, 2015b). In the 2008 study among young people, almost half (48%) of female respondents reported 'ever forced sex', against one-quarter (25%) of males, most often by older males. Perpetrators of forced sex were mostly partners or 'friends' (MHMS, 2008). The same study also included ANC women, 29 percent of whom reported ever been forced to have sex.

The 2009 UNICEF study, which included sub-samples of most-at-risk and especially vulnerable adolescents and young people, showed even more worrying results: 38.1 percent of sexually active youth reported that they had been forced to have sex when they did not want to, with a large majority of 71 percent saying they were still vulnerable. The results showed stark variations across the different provinces, with more than two-thirds (68.3%) of youth in Choiseul reporting forced sex against 43.3 percent in Western Province; 30.4 percent in Malaita and 23.3 percent in Honiara (UNICEF, 2010). Differences were even bigger among different groups of youth: 'mainstream' youth (17.3%), compared to most-at-risk

adolescents (70.5%) and especially vulnerable young people (82.4%): these results show the need for accurate targeting of HIV/STI-prevention interventions, and the need to place these interventions in a wider perspective of sexual and reproductive health and rights, with *special attention for gender-based violence*.

A recent report gives further evidence of alarming types of sexual abuse, trafficking and sexual exploitation of children. It mentions that double standards attached to marriage and sexuality codes contribute to weaken women's intra-household bargaining power, thus reinforcing girls' and women's vulnerability to exploitation such as trafficking and commercial sexual exploitation. Findings from Choiseul Province in particular show an alarming influence of gender power relations involved in the recruitment of girls for transactional sex with logging workers (*Kojima et al, 2015*). Logging sites and fisheries are mentioned as key risk areas for exposure to child trafficking and CSEC: children may go to logging or fishery sites to engage in vending or small jobs, and often get cash, alcohol or goods from foreign or local workers in exchange for running errands. So-called *solairs* are intermediaries who arrange local girls for foreign or fishery workers. Often, local girls working as house girls engage in transactional sex or forced sex.

Target 8: Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

7. Critical enablers

7.1 Policy dialogue

The 2011 – 2015 National Strategic Plan was reviewed in 2014 and the newly reviewed National Strategic Plan 2014-2018 (draft) has identified legal and policy reform as a national response priority for the period 2014-2018.

7.2 Stigma reduction

Solomon Islands as a country, has no specific discriminatory laws and regulations to protect the rights of people living with HIV, or those of particularly vulnerable groups. However it does have in its Constitution under Section 15, a provision for discrimination which protects its citizen from any form of discrimination.

In 2014, there was no progress towards the protection or fulfillment of the rights of some vulnerable populations, or towards minimizing their vulnerability. Political leadership, media coverage and public advocacy efforts in support of the HIV response waned in 2013. No progress towards the development of HIV-related legislation was achieved during the year and Solomon Islands laws that discriminate against men who have sex with men and sex workers continue to impede prevention efforts.

7.3 Law reform and enforcement

Solomon Islands has no explicit anti-discrimination laws or regulations to protect the rights of people living with HIV. Section 15 of the Constitution makes discrimination unlawful on the grounds of race, place of origin, political opinions, color, creed or sex. There are very weak legal protections for vulnerable groups and no specific protections for people living with HIV or those assumed to have HIV by reason of their membership in a vulnerable group.

Homosexual acts (sodomy) are criminalised in Section 160 of the Solomon Islands Penal Code; ‘buggery’ with another person, the permitting of a person to commit buggery on him or her; and attempts. Section 161 of the Penal Code outlines the lesser offence of ‘committing any act of gross indecency’ by persons of the same sex. Attempting to procure another person of the same sex to commit an act of indecency is an offence.

Offences relating to sex work in the Solomon Islands Penal Code include ‘knowingly living on the earnings of prostitution’ (Section153), ‘soliciting in a public place for immoral purposes’ (Section153), ‘aiding, abetting or compelling the prostitution of a prostitute for the purpose of gain’ (Section153), ‘keeping a brothel’ (Section155), and ‘permitting premises to be used as a brothel’ (Section155).

An HIV Legislative Working Group was established in 2009 to analyze legislative gaps and examine legal reforms towards addressing them. The HIV Legislative Taskforce developed a draft **HIV Management, Prevention and Control Legislation** in May 2012 and produced a Cabinet Paper to guide the process for a HIV Bill to be passed through the Ministry of Health and Medical Services for review, and tabled in Parliament. The proposed Bill incorporates international good practices outlined for the *United Nations International Guidelines on HIV and Human Rights*, the *Handbook for Legislators on HIV and the Pacific*, and *Enabling HIV Responses: HIV for Pacific Islands Countries*. No progress toward development of the HIV Bill was made in 2014.

7.4 AIDS-specific institutional development/community mobilization

The MHMS STI/HIV Unit has continued to benefit from capacity building programmes of partners, with one staff attending specialized training in HIV Testing and Counselling at Empower Pacific in 2014 sponsored by UNICEF.

UNICEF also sponsored one youth from SIPPA, a local NGO to attend the AIDS 2014 International AIDS Conference in Melbourne, Australia. The youth was facilitated to attend this conference so as to come and share his key messages and lessons learned at the conference as well as replicate best practices from other countries with his fellow youths in the Solomon Islands.

Target 9: Eliminate HIV-related restrictions on entry, stay and residence

8. Progress made in amendment and removal of such laws

The Ministry of Health and Medical Services is currently in discussions with the Solomon Islands Department of Immigrations to review a law that forbids HIV positive individuals from entering the Solomon Islands. The MHMS acknowledges that such a law is an infringement on the rights of Persons Living with HIV (PLHIV) and hence could discourage uptake of HIV testing and counselling and disclosure in the fight against HIV in the country.

Target 10: Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

9. Synergies with development sectors

It is important to note that while the health sector plays a key role in promoting the health and well-being of the country, the social determinants of health highlight the need for multi-sectoral action across government sectors (for example, trade and economy, education, infrastructure), and non-state actors and cultural leaders to improve health outcomes.

9.1 Social protection

Bearing in mind that any service delivery model has to be based on affordability, cost-effectiveness, efficiency and equity, we identify areas of social inclusion in existing government plans, and service delivery models which aim to meet the needs of the most vulnerable.

The Role Delineation Policy (RDP) is the backbone of planning service delivery and essential packages of care. As implementation of the RDP unfolds it will be important that user perspectives, opportunities for integrating vertical programs, and reaching unreached populations such as youth and people with disability are given due attention. Physical mapping of facilities, populations and topography to allow travel times to be measured will be necessary to assess where the gaps in service coverage are and where future expansion should take place.

To improve privacy for counselling and space for youth friendly services, MHMS could plans that space and appropriate layouts are incorporated into any upgrading or building of new clinics. However, access of physically challenged persons also needs to be taken into account. New clinic buildings need to be designed to be accessible to persons with disability. For existing clinics, plans need to be developed for providing care to persons who cannot physically access the clinic.

Central to the rebalancing agenda is an enhanced push for more outreach and more effective health promotion. This has organisational, programmatic and budget implications at the national and provincial level. Greater integration of national programs and services at the provincial level could result in more effective service delivery and health promotion, and increase efficiency.

At a practical level, improved outreach and health promotion has implications for how nurses and nurse aides work together with health promotion officers. Institutional change and program integration will require policy level reform, the amendment of unfriendly HIV laws will particularly be instrumental.

Men have poor access to sexual health care, are common perpetrators of family violence, and play minor roles in taking responsibility for reproductive and family health. The network of male nurses exposed to the men as partners in reproductive health training are a valuable resource for championing male involvement and responsibility.

9.2 Gender programmes

Gender mainstreaming (GM) is no longer just the business of the Ministry of Women (MWYCFA). The Public Service Commission (PSC) has taken leadership in pursuing a whole of Government responsibility for this. In March 2013, the PSC took the significant step as part of the public service reforms, to have all permanent secretaries sign a performance contract which includes GM as one of the seven common or 'generic' principal Key Performance Indicators (KPIs) with six performance measures.

These are:

- Having a gender implementation strategy as part of the Corporate Plan
- Appointment of a gender focal point/gender desk
- Evidence of gender sensitivity within the recruitment and selection process in the Ministry
- Gender profiles and statistics collected and disseminated
- Zero tolerance on work place harassment including sexual harassment
- Gender report to be part of the monthly and annual reporting processes.

The Gender Focal Point (GFP) in the MHMS has been assigned to the Senior Planning Officer. Although a new post has not been created, the GFP plays an influential role in assisting the PS to fulfill their contractual obligations. The GFP reports directly to the PS, and is responsible for coordinating the ministry-wide activities linked to the gender mainstreaming performance KPI. The GFP leads the ministry's response to gender issues, and initiates the process of developing the Gender Implementation Strategy and work plan.

The gender mainstreaming contractual requirement and the KPIs provide a high level entry point for MHMS to position Gender Equity and Social Inclusion (GESI), and to consider developing a GESI strategy and implementation plan as an expansion of the required gender strategy. It was made clear that some technical support will be required to support a ministry

led and owned process, as Gender and GESI are relatively new approaches in the Solomon Islands with few if any national technical experts.

In 2014, the Gender Focal Point identified activities to progress the development of a gender strategy though little progress had been made. Planned activities include: gender awareness raising and a gender mapping exercise, data collection and evidence gathering, the development of gender indicators to incorporate into a review of the Health Information System, and the development of gender training and guidelines to integrate into existing training programs. There are GESI champions in the MHMS but they are not working in a coordinated way to push the agenda forward. For example, the 100 male nurses that have been trained in the area of men as partners in reproductive health have had few opportunities for advocacy activities post training, though the Director and Deputy Director Nursing are champions of male involvement.

9.3 Education

The social determinants of health and the barriers to accessing health information and services provide the context in which demand side interventions seek to promote healthy living and change harmful behaviours. Health promotion to reduce individual and family related risk factors is a national health priority, and given the evidence presented by the various studies cited in this report, improving reproductive and sexual health behaviours, and preventing non-communicable diseases are two priority areas of behaviour change through health education and promotion.

The National Development Priority, NDS Objective 3 aims to “Ensure all have access to quality health care and combat malaria, HIV, non-communicable diseases and other diseases;” and Objective 4 aims to “Ensure all access quality education and the nation’s manpower needs are sustainably met.”

MHMS has a MOU with the Ministry of Education to work together on health promotion for young people through information technologies. Arrangements to work with NGOs and non-state actors more broadly are less formal. However, as reported in the last GARPR, the open and collaborative relationship between government and civil society is an example of good practice and a contributing factor to the steady progress being made in raising awareness about HIV/AIDS and reaching hard to reach populations.

9.4 Workplace

There is no evidence to show the existence of promotion of workplace HIV in the country, and this practice may only exist within the individual policies of the Development Partners and International NGOs working in the Country.

No specific National HIV/AIDS policy exists in the country and therefore the SIG has no HIV workplace policies. However, this may be actionable in future given the current policy

dialogue ongoing within the MHMS and the other SIG arms of government regarding amendment and or removal of unfriendly HIV policies from the constitution.

9.5 Synergies with health sector

One of the two central focus areas of the Solomon Island National Development Strategy (2011-2020) is *Taking better care of all the people of the Solomon Islands*, under which a specific objective has been identified to ensure access to quality health care and combat HIV & other diseases (Objective No.3). The National Development Strategy specifically outlines a need to develop a national HIV framework. Therefore, the Solomon Islands National Strategic Plan (NSP) for HIV and STIs 2011-2015 was developed in 2012 to provide strategic guidance and direction to all individuals, groups, organisations and agencies responsible for contributing to the national HIV and STI response in the Solomon Islands. The NSP is also guided by the commitment of the Government of the Solomon Islands to its people as documented in the overarching vision statement of the National Health Strategic Plan (2011 – 2015): *The people of the Solomon Islands will be Healthy, Happy and Productive.*

The main priority of the NSP is to re-direct high impact interventions to the underserved and most at risk population groups. This NSP places particular emphasis on improved communication to halt the transmission of HIV and STIs through informed HIV and STIs awareness and behaviour change interventions, as well as improved access to quality prevention, care and support services aimed of enhancing the quality of life and dignity of PLHIV and affected persons, as well as reduction in the transmission of HIV and STIs to others.

The STI/HIV Unit has been making efforts to integrate with other divisions in the ministry, through inclusion of some HIV indicators in the HMIS of the MHMS. However, HIV indicators are not included in the NHSP 2011-2015 except for the indicator measuring STI/HIV surveillance studies conducted in the country.

There is need to do more in terms of Joint planning with other Units eg RH and Gender Unit, participation in Joint sector meetings and incorporation of all HIV national indicators in the national database.

IV. BEST PRACTICES

A1) Lessons learned relate to the (A) *programmatic* level as well as the (B) *strategic* level. At the *programmatic* level, the first lesson learned is the importance of *strengthening HIV testing* as the entry point to treatment, care and support, as well as prevention – i.e. treatment as prevention, PMTCT and prevention of HIV transmission to partners. Increased HIV testing will also allow the (timely) detection of HIV cases that have been hidden to date. This requires a shift from the current focus on (passive) *client-initiated* voluntary counselling and testing towards (proactive) *provider-initiated* testing and counselling (PITC) in the context of health care (e.g. antenatal women, STI and TB patients) and through (peer) outreach programmes to key populations. Replication of best practices from other PICTs is recommended E.g. positive experiences on mobile HIV test units and youth-friendly services in Cook Islands.

A2) In the context of very low HIV prevalence, programmes and services need to have a *stronger focus on key populations and other vulnerable groups*. Limited resources, especially with decreasing donor funding, need to be used for programmes that are tailored to the specific needs of MSM, transgender persons, sex workers and their clients, (young) women and men engaging in transactional sex; mobile men, including seafarers and uniformed men. To this effect, *partnerships and effective referral* between government health and social services and civil society organisations – including organisations of PLHIV and organisations working with MSM and sex workers – need to be established and/or strengthened.

A3) *Strengthening coverage, comprehensiveness and quality of programmes for key and other vulnerable populations*: the current low coverage highlights the need to develop and offer services that are better-tailored to the needs and expectations of specific populations. This requires: a) a *better understanding* of their characteristics through adequate size estimations and mapping, as well as qualitative socio-behavioural research to identify hidden populations and develop specific approaches to effectively reach them; b) Services need to be *better tailored* to the needs of specific groups: this requires ongoing revision of service packages and active involvement of sub-populations concerned in developing them. c) *Comprehensiveness and quality* of services are crucial: this requires diversification of services, a focus on lowering service thresholds, and more proactive approaches to delivering services.

A4) *Treatment, care and support*: as mentioned above, more proactive provider-initiated testing and counselling –especially among key populations – is crucial for scaling up ART coverage, which in turn contributes to prevention (TasP). This involves more involvement of PLHIV and key populations and close collaboration with health and social services. Furthermore, the quality of treatment, care and support need to be improved to ensure treatment adherence. Special attention is needed for strengthening laboratory systems for monitoring ART patients, as well as early infant diagnosis. The rollout of test-and-treat approach is recommended as will further simplify the technicality of determining when to initiate ART in PLHIV, and early treatment will reduce AIDS related deaths in the country.

B1) Lessons learned at the *strategic* level involve the conditions in which services are delivered, and the support systems that need to be in place to sustain them. First of all, *strengthening enabling environments* is crucial for effective implementation of programmes and services. This involves: 1) Addressing *legislation* that criminalises sex workers and MSM or hampers the rights and free movement of PLHIV; 2) Strengthening the *commitment and involvement of governments* to prioritise HIV/STI programmes in the wider context of sexual and reproductive health; and allocate sufficient local resources to ensure sustainability;

3) Address the HIV-related prevailing *stigma and discrimination* at the level of communities and society as a whole through awareness and media advocacy programmes.

B2) Secondly, *structural challenges* related to the geographic realities of the country and widely dispersed small islands can only be overcome by *increased integration* of HIV/AIDS-related services in existing health, social, and other services. This requires integrating HIV-related interventions in public health-care systems, sexual and reproductive health (SRH: including STI services), public education and information services. One of the key lessons learned from the 5-year *Pacific Islands Response Fund for HIV & STIs*, which provided almost USD 22 million to the Pacific region in the 2009-2014 period, was that there is a need for integrated SRH and well-being strategic plans and a move away from HIV-focused NSPs (SPC, 2014c). The recent launch of the *2015-2019 Pacific Sexual Health & Well-being Shared Agenda* (SPC, 2014b) reflects an increasing recognition that HIV in the Pacific cannot be addressed as a stand-alone issue, but needs to be understood and dealt with in a broader context. Integration of HIV/AIDS in existing programmes and services of the health and other sectors will allow more cost-effective implementation.

B3) Civil society plays a key role in the national response. Experiences with the Australian-supported Response Fund have shown the importance of involving communities and NGOs in local programmes and for reaching key populations. In this regard, *strengthening civil society* involvement requires technical capacity building of CSO staff and volunteers, as well as organisational and institutional strengthening. In order to improve sustainability of CSO programmes, they need to strengthen their skills in the field of management, financial systems, resource mobilisation, human resource management and M&E.

B4) Special attention needs to be given to the *gender dimensions of HIV risks and vulnerabilities*. More specific attention needs to be given to the impact of gender-based and intimate-partner violence, including rape, on the possibility for women and girls to decide on their own sexual and reproductive health and rights, including preventing HIV infection. This includes a stronger focus on protection of victims and prosecution of perpetrators in close collaboration with social services and the justice system. In addition, men and young men need to be more involved in SRH (including ANC) services, including as an entry point to PITC.

B5) *Strategic information* needs to be the basis for, and guide the implementation of all HIV programmes and services. This requires strengthening routine surveillance and reporting systems, research and M&E systems. Low coverage and limited impact of programmes tends to be due to a limited understanding of the real drivers of the epidemic, of the populations most at risk, and their service needs. In addition, M&E and operational research need to be used systematically for adjusting and improving programmes that they respond to priority needs of beneficiaries.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

In Solomon Islands, a number of human rights barriers hamper access to health and HIV-related services for specific groups. Discriminatory legislation, policy and social practices remain in place that act as barriers to sexual health and well-being and promote stigma and discrimination. Specific aspects include: 1) *Legal frameworks that criminalise sex work and male-to-male sex*; and 2) *Gender inequalities* (norms, practices) that affect access of specific groups of women, girls, men and boys to health services, and HIV prevention, care and treatment in particular.

1) Key human rights barriers affecting access to health services

Legal frameworks that criminalise sex work and men who have sex with men (MSM) constitute an important human rights barrier to effective HIV service delivery.

Criminalisation of sex work – As mentioned above (1.1.b), “*selling sex, owning a brothel or aiding or abetting prostitution for personal gain*” are illegal under Section 153 and 155 of the Solomon Islands Penal Code. The criminalisation, punitive practices of law enforcement and other legal oppression of sex work create structural barriers to HIV/STI prevention and have a negative effect on community empowerment-based HIV programming. In addition, criminalisation may reinforce discriminatory and punitive attitudes at the community level and in health-care settings: e.g., experiences from Fiji show that the introduction of heavier penalties for people associated with the sex industry in 2010 had a negative impact on HIV responses (McMillan, 2013).

Criminalisation of homosexual acts – As mentioned in the previous sub-section (1.1.b), sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. Criminalisation of homosexuality is common in other countries in the Western Pacific, many of which have laws penalising “*homosexual acts and sodomy*”; prohibiting “*buggery*” or “*permitting buggery*” and “*gross acts of indecency between males whether in public or in private*”. Other legal terms used to criminalise sex between men include prohibition of “*indecent acts between males, regardless of consent*” and “*sodomy, including between adult males*” or “*the impersonation of a female by a male*” (Cooper, 2013).

The fact that these laws exist does not mean that they are strictly enforced: sex workers, women or men engaging in transactional sex, MSM or transgender people are not systematically prosecuted in Solomon Islands. However, as a result of official legislation criminalising sex work and homosexual acts, the Ministry of Health and Medical Services and civil society service providers may feel restricted to offer services or programmes that specifically target sex workers or MSM, “*because they engage in illegal behaviours*”. Thus, with many competing priorities and limited budgets, services for these populations are not prioritised. As a result, specific programmes for these key populations often depend on external donors and lack sustainability beyond the end of short-term projects. In addition, the existing legislation reflects *prevailing social norms and values that stigmatise and discriminate* against sex workers and MSM. Negative attitudes of health-care workers may pose a barrier for members of key populations to seek sexual and reproductive health services, HIV testing, access prevention services, or ART services.

2) Gender inequalities (norms, practices) that affect access of specific groups of women, girls, men and boys to health services, and HIV prevention, care and treatment in particular.

Traditional and more recently introduced norms and values on gender roles – In Solomon Islands, prevailing norms and values tend to strongly confirm the dominance of male over female gender roles. Women are sidelined when it comes to decision making at the household, community and national level. Traditionally, the country had a matrilineal land system whereby women played a significant role in the decision making on land and resource management and were highly respected. However, over the years these roles eroded with the introduction of patriarchal religious, legal, economic and political systems (SPC, 2012). As a result, currently, women’s rights to equal participation in the workforce and household, as well as in customary decisions are largely denied, as reflected by a saying among the Wontok people that goes “*women no save tok*” (women cannot/must not talk) (Taylor et al, 2013). The custom of *women no save tok* has constrained women’s participation in decision making at all levels. Male dominance and power over women has also contributed to severe domestic and gender-based violence against women and girls, where women are supposed to remain silent and not shame the family and community (Taylor et al, 2013). Research shows that many women have absorbed these social norms: the majority of women agree with statements such as “a man should show his wife who is the boss” (71%); and “a goodwife obeys her husband even if she disagrees” (66%). Overall, 73 percent of women agree there is at least one situation where a man has a good reason to beat his wife (SPC, 2009).

The *prevailing norms and values on the position of men and women also affect the health-seeking behaviour of women and girls*, as well as attitudes of health-care workers toward young women and men seeking sexual and reproductive health and HIV-related services. *Women are less likely to seek help when they are sick*, and the sex of a health worker may be a barrier: women are reluctant to have a male nurse undertake a physical, especially gynaecological, examination (Thomas et al, 2014). *Wantok* and kinship structures may also influence health behaviours. Data on general new consultations in health facilities at the national level in 2013 show a proportion of 55 percent men vs. 45 percent women. Women, especially those living in rural areas, continue to face difficulties in accessing family planning services. Another indication is that male babies have a higher vaccination rate than their female counterparts (90% and 75% respectively) (SINSO, 2007).

They are also reflected in laws regarding the protection of women and girls against sexual and intimate partner violence, including rape within marriage. As a result, women and girls in the Pacific region are often deprived of the power to make decisions about their sexual and reproductive health. Studies have found that *young people are particularly at risk as they are more likely to lack control over their sexual and reproductive health* (SPC, 2014b). An open hearing in 2012 on adolescent sexual and reproductive health in the Pacific found limited access to youth-friendly services, contraception and comprehensive sexuality education; a lack of meaningful engagement with young people; lack of access to safe abortion; and social, gender, cultural and religious norms that put young people at greater risk of poor sexual and reproductive health in the Pacific (SPC, 2014b).

The complexity of the social and cultural factors that affect health cannot be understated as they play out in multiple forms, sometimes presenting as a barrier and then at times an enabler of development. All stakeholder groups consider gender norms, culture, and *kastom* to be key inter-related factors that impact on health outcomes and behaviours in Solomon islands, including the high prevalence of violence against women and girls, and low male

involvement in the care of children. Although some ethnic groups practice matrilineal inheritance, across the country, men dominate decision-making at all levels of society.

Gender inequalities lead to differential access to services for men and women, as well as for young people. Women – particularly young women – have less control over decisions regarding sexual and reproductive health, which may increase their vulnerability to HIV and STIs. E.g. women often have less control than men over decisions on contraceptive use, safe sex and casual partners of husbands or boyfriends, which increases their risk of exposure to HIV and STIs.

Religion and spiritual beliefs play a strong part in people's everyday lives. Competition between church affiliated groups sometimes leads to violent conflict. The practice of demanding compensation for social and legal wrong-doing is widespread and inhibits individuals and families seeking justice, such as in the case of violence against women, and has been known to be charged against health workers.

Strong kinship bonds and *wantok* identity is a social asset that fosters social cohesion and helps mobilise communities behind development agendas. However, as in the case of violence against women and girls, kinship and obligation inhibit families and women from seeking social justice as *wantok* allegiance and its maintenance takes precedence. As to be expected, in areas where social cohesion is strong, such as Isabel where one religious denomination holds sway, it is reported that it is easier to mobilise the community behind health and other development agendas.

Sexual and gender-based violence – including intimate-partner violence and rape, as well as violence against non-conforming gender identities (LGBT) – is widespread in Solomon Islands, as well as in other Pacific countries. Studies conducted by UNICEF in Solomon Islands, Vanuatu and Kiribati found that between 38-45% of sexually active youth had experienced forced sex, with approximately 20% reporting that their first sexual encounter was forced (SPC, 2014b). Sexual assault during childhood and adolescence has been linked to earlier sexual debut, sex with multiple partners, unprotected sex, transmission of STIs and early pregnancy (SPC, 2014b). Furthermore, outdated criminal codes continue to exist that do not comprehensively address marital rape, sexual assault of children, trafficking and harmful traditional practices (SPC 2013c). In addition, the rape of boys or men is usually not recognised or penalised in the Penal Code, rendering boys or MSM particularly vulnerable to sexual abuse. Even when rape in marriage is illegal, cultural values tend to place the blame for rape on the survivor rather than the perpetrator (Cooper, 2013). This makes it difficult for women to seek medical and legal support in cases of sexual violence.

Limited involvement of men in reproductive health services – As in many other PICT countries, HIV programmes for key populations are limited in Solomon Islands: most HIV-related services target the general population and are often integrated in antenatal care services for pregnant women; while men are often reluctant to seek health services. E.g., a large proportion of HIV tests is conducted among pregnant women. As a result, men and boys have often less access to HIV-related services, especially HIV testing and associated services such as ART. In addition, current HIV and AIDS messages and approaches are less effective because they are often gender insensitive, culturally inappropriate or often misunderstood (UNDP, 2013).

3) Structural challenges

The geographic context of Solomon Islands presents major logistical and financial challenges. The per-capita cost of reaching small populations who are living in widely dispersed islands is extremely high. As a result, many interventions – especially for HIV prevention – are confined to the (few) main urban centres, with limited or no coverage in outer islands and rural areas.

Physical factors such as geography and transport are identified as barriers to accessing health services, employment opportunities and information.

4) *Stigma & discrimination* – especially towards key populations – hampers effective service delivery to sex workers and MSM. While there is traditional acceptance/tolerance of transgender persons, national laws and traditional cultural and religious norms and values strongly reject homosexuality, which makes it difficult to identify and reach these groups. Prevailing national laws and norms also prevent policy makers from prioritising programmes and allocating funds to these groups, while self-stigma keeps people from seeking services tailored to their needs, as they prefer to keep a low profile. Another prominent issue is the lack of confidentiality in small communities where “everyone knows everyone”.

5) *Legal and policy environments*

HIV prevalence remains very low in Solomon Islands. With many competing priorities and a limited government budget, HIV is low on the list of health and social priorities. As a result, the national response to HIV has heavily depended on external financial and technical support, with limited ownership and political and financial commitment, as evidenced by the limited annual SIG allocation of approximately SBD 150,000 only to the national response for the past two years. Resourcing and funding for sexual and reproductive health and HIV is for the most part funded by donors and development partners. The country also relies heavily on regional technical agencies and CSOs to provide technical assistance, as most Pacific Island Countries lack the capacity to fully provide the necessary services and programmes. (SPC, 2014b). Thus, the long-term sustainability of the response beyond the short to mid-term support from external donors is limited, unless HIV-related services are integrated into broader programmes, such as sexual and reproductive health and public health systems.

In the *legal* sphere, criminalisation and punitive laws and regulations against sex work and homosexual acts continue to drive people underground and prevent governments from making targeted services available to these key populations. Sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. Both selling sex as well as owning a brothel or “aiding or abetting” prostitution for personal gain are illegal under Section 153 and 155 of the penal code. The current legal ground creates challenges for accessing most-at-risk populations for prevention and surveillance purposes.

Limitations of the Solomon Islands National AIDS Council (SINAC) the supposed coordinating body for the national response, has to-date impeded effective resource mobilisation, coordination, monitoring and evaluation of the response. Since 2011, there has been low engagement among SINAC members and limited commitment and capacity among SINAC leadership and staff to carry out the Council’s national steering role. No representatives of SINAC spoke publicly or in the media on any HIV related topic / policy or

in support of the response in 2013 and 2014. National level political changes, internal capacity gaps, and a reduction in the involvement of Civil Society stakeholders due to lack of funding and donor support, has eroded the effectiveness of SINAC, and has adversely impacted on the progress and performance of the national HIV response. In addition, an overlap of roles with Solomon Islands' National Country Coordinating Mechanism (SINCCM), whose mandate includes managing, coordinating and implementing the Global Fund Grant for Tuberculosis, HIV/AIDS and Malaria, has weakened SINAC's influence and profile. All these challenges have significantly impeded SINAC from playing an advocacy role for policy reforms and increased funding allocation for the national response.

Solomon Islands as a country has no specific anti-discriminatory laws and regulations to protect the rights of people living with HIV, or those of particularly vulnerable groups. However it does have in its Constitution under Section 15, a provision for discrimination which protects its citizen from any form of discrimination. In 2014, there was no progress towards the protection or fulfillment of the rights of some vulnerable populations, or towards minimising their vulnerability. Political leadership, media coverage and public advocacy efforts in support of the HIV response waned in 2013. No progress towards the development of HIV-related legislation has been achieved to-date.

6) Health systems challenges

Solomon Islands Government is the main provider of health services in the country and employs 97% of the country's health professionals. In 2013, Solomon Islands Government (SIG) employed 1,827 health workers of which 5.9% were doctors, 44.3% nurses and 5.9% nurse aides. With 1.71 health workers (doctors, nurses and midwives) per 1,000 population, this is well below the WHO minimum threshold of 2.3 workers per 1,000 population. Women make up 66.6% of the nurses and nurse aides but only 20.6% of doctors. All executive positions in MHMS are held by men, as are all nurse leadership positions. Male dominated leadership cuts across Solomon Islands political, cultural and religious domains.

The uneven distribution of health workers across the country impacts on access to services and quality of care. Skilled health workers are concentrated in Honiara where only 12.5% of the country's population lives, and continuing migration of health workers to Honiara is likely to deepen the imbalance. In 2013, the doctor: population ratio was 1:1,319 in Honiara and 1:18,929 in rural areas; the nurse: population ratio was 1:305 in Honiara and 1:885 in rural areas. Human resources are also inequitably distributed across the provinces.

The concentration of medical and specialist health staff in Honiara fuels high referral costs for the health system as well as adding strain on family incomes as people have to cover time away from their livelihoods, and living expenses while in Honiara. It also encourages by-passing of primary health care facilities, increasing the cost to the system of delivering primary level care, as well as the out of pocket spending users make on services that could be provided closer to home.

The Government's commitment to free health services, while a laudable equity principle, does not incentivise care seeking at lower levels of the service delivery chain and as demands for hospital level care increase this may put further pressure on the National Referral Hospital (NRH). Renbel with 0.6% of the national population has no provincial hospital, but nearly ten times the number of referrals to NRH than other provinces (*Negin, 2011*).

Poor working conditions, lack of or poor quality accommodation and lack of school opportunities for children in rural areas increasingly discourage staff from taking rural and remote postings as expectations rise. Unattractive remuneration packages and limited support provided to health workers further add to the low morale reported. Absenteeism and the difficulty in retaining staff in rural areas has been recognised by all stakeholder groups; leaving some areas underserved. Weak supervision throughout the health system partly linked to high transport costs, lack of funding and low prioritisation, contributes to the problem of absenteeism. Nurses at Kukum Health Clinic in Honiara, during the 2014 GESI study, reported high workloads, limited support, and few promotion prospects. They also felt that the Nursing Council was not an effective advocate for nursing in the country, and provided no tangible benefits to those registered.

Due to a lack of skills and equipment in-country some HIV&AIDS related testing has to be sent out to Fiji and Australia. This is costly and time-consuming. In 2013, Kukum clinic in Honiara sent a sample for gonorrhoea testing to Fiji in January and the results were returned in October after a baby was born with an eye infection; the mother was positive. It was confirmed that test results were delayed that year because MHMS held outstanding bills.

Also according the 2014 GESI study, a major HRH issue that the country is facing that could distort resourcing is the imminent return of 100 Cuban trained doctors. While the new stock of doctors will help fill gaps in the country the large allowances they are entitled to will significantly raise the salary budget. This is at a time when a government employment freeze has left graduating nurses without jobs and as the numbers of retiring nurses is expected to increase. The impact of these challenging HRH decisions carries a strong weight, especially as urban elites and influential members of society are demanding higher level services that are at odds with the PHC focus of the health system.

Going forward, posting and retaining health workers in rural and remote areas will be key to assuring access to health services. This will require carefully crafted strategies to motivate and support nurses in rural and remote settings. This may include financial allowances, aligning nurse promotion prospects and training opportunities with time spent in rural facilities, improved clinic environments and better supportive supervision. Further work possibly linked to the implementation of the Rural Development Policy is needed to assess what is needed to retain and motivate rural nurses. The Role Delineation Policy (RDP) that was approved in 2014 by the Health Minister sets the norms for the organisation and staffing of the health sector, and the parameters for future expansion of the health network. It also provides the basis for defining the essential packages of care. As such, the role delineation policy has important implications for ensuring equitable access to services and reaching underserved groups, and potentially for defining remote area packages of care. While expansion of the health facility network is not planned for the next three years, implementation of the policy will require the physical mapping of facilities and populations and topography. This exercise will enable MHMS, community representatives and citizens to assess the gaps in the current spread of health facilities and identify where new facilities are needed. Stakeholder buy-in to the RDP will be essential to bring political, church and community groups on board to avoid the building of ad-hoc clinics.

7) HIV-prevention services

I Solomon Islands, these have so far tended to focus on the general population or in-school youth, with very limited services for key populations or other vulnerable groups. In part this

is due to the limited research and the inadequate understanding of the risk dynamics and needs of the different groups. As mentioned, there is little differentiation between MSM, transgenders, bisexual men and other sexual minorities; or between commercial sex workers and women and girls engaging in transactional sex. Similarly, the specific HIV risks of mobile men, such as seafarers, fisher folk, taxi drivers, or uniformed men have not been clearly identified. The lack of adequate population-size estimations makes it difficult to set realistic targets and achieve sufficient coverage. Services and programmes for vulnerable and marginalised populations have in the past been offered by Save the Children and SIPPA, but the programmes ended over two years ago, leaving a gap of unreached key populations with HIV/STI prevention information and services. Many services have focused on married women and expecting mothers whereas the range of specifically designed services for single women, older women, men and transgender people is low. This leaves unmarried men and women, not pregnant women, youth, LGBT, and other marginalised populations often unable to access sexual health services. Similarly, young people often lack correct information, are exposed to misinformation, and have many questions but do not know where they can find reliable answers. The country is currently in the process of integrating comprehensive sexuality education in schools. Youth friendly health services are available in only seven (7) facilities across the country. Generally, coverage of YFHS in the PICTs remains low, with between 10% and 23% of young people utilising existing youth-friendly services (SPC, 2014b).

While there are very few cases of HIV-infected pregnant women, the existing *PMTCT* protocols have not been adequately implemented especially in the area of ART for infants and Early Infant Diagnosis (EID). Coverage of HIV testing among antenatal women is low at 29% (GARPR 2015), and this means potential HIV-positive mothers miss the opportunity of being enrolled in PMTCT and ART. *Limited laboratory infrastructure* and long delays in sending blood samples to laboratories in Australia seriously hamper early infant diagnosis (EID).

8) Treatment, Care and Support

TC&S services are available, but even with very low numbers of HIV cases, not all eligible patients are successfully enrolled and monitored in care and treatment, including ART. Patients continue to die due to non-response to treatment or adherence challenges. Although the most AIDS deaths have been among HIV patients detected in advanced stages of HIV disease, the risk of late diagnosis and premature death continues to be a problem due to the low HIV testing coverage and inadequate treatment management compounded by the limited laboratory capacity and equipment, which hampers effective patient monitoring.

9) Strategic information

Despite clear articulation of the importance of strengthening strategic information in the NSP, many gaps and challenges remain: *limited research* has been done among key populations to identify specific sub-populations among MSM, sex workers that are particularly hidden and (hence) hard to reach. In this context, the dynamics of sexual networks are not sufficiently understood to develop targeted programmes for these groups. *Monitoring and evaluation* tends to be geared toward reporting to donors. The government and national NGOs have limited or no systems to monitor and evaluate their programmes, and use M&E data to inform programming decisions. There is a particular lack of operational research, which allows

identifying effective approaches. Thus, many services are implemented with a focus on (donor-driven) “delivering outputs” rather than achieving meaningful outcomes and impacts.

10) Socio-economic Challenges

The Household Income and Expenditure Survey (HIES) (2005/6) provides the most recent estimates of poverty distribution in the country. A repeat HIES was expected in 2014 but it did not happen. The 2005/6 survey reported an incidence of basic needs poverty at 22.7% of the population. This varied from 32.2% for Honiara, 13.6% for provincial urban, and 18.8% for rural populations. An additional large number of people live just above the poverty line and are vulnerable to falling into poverty.

The lack of reliable and up-to-date health outcome data disaggregated by poverty makes it difficult to identify common patterns of inequality across health indicators, although certain disparities and vulnerabilities are evident. First, women and girls are highly vulnerable to family violence, which carries personal, family and public health costs. Second, geographical remoteness is linked to poverty and poor access to services such as in the case of Choiseul where maternal deaths are higher than average.

Urbanisation: Twenty per cent of the population live in urban areas, and the urban growth rate was estimated at 4.7 per cent in 2009, the highest in the Pacific region. Honiara is the main urban centre and as noted above has the highest poverty levels in the country. Informants from the MHMS reported that migration to Honiara is not slowing as people from outlying islands seek employment and access to services. UNICEF reports that the number of informal settlements in Honiara now stands at 52 growing from 30 in 1989. Poor access to basic amenities and health services places poor peri-urban communities at high risk. Health clinics serving Honiara city by the Honiara City Council, and Honiara Referral Hospital have very high patient loads, and are struggling to keep up with the growing urban population and increasing demand for hospital services from outer islands.

Employment, education, and links to wealth and poverty are perceived to impact on health outcomes, and people’s ability to access health information including SRH and HIV/AIDS information, services and pay for nutritious diets especially for PLHIV.

VI. SUPPORT FROM THE COUNTRY’S DEVELOPMENT PARTNERS

In 2015, the Ministry of Health and Medical Services continued receiving major support for the response from UNICEF, in terms of financial support and technical assistance to implement the programme activities.

VII. MONITORING AND EVALUATION ENVIRONMENT

The MHMS national HIV/STI response, with support from UNICEF, has since 2013 developed a number of data collection and reporting registers and tools to monitor the response at facility, zonal and provincial levels; in the programme areas of HIV testing and counseling, PMTCT, and STI diagnosis and treatment. Data collection tools in the forms of registers and summary report forms have been distributed to the provincial health facilities to ensure regular reporting. Registers currently being used include 1) *HIV Testing and Counselling Zonal monthly report form for STI, TB and VCT services*; 2) *HIV Testing and Counselling Zonal monthly report form for ANC services*; 3) *HIV Testing and Counselling Provincial Consolidated (monthly) report form*; 4) *HIV Testing and Counselling Provincial*

monthly report form for ANC services; and 5) HIV Testing and Counselling Provincial monthly Report form for STI, TB and VCT services. Data-collection summary report forms currently rolled out to the health facilities include 1) HIS monthly report form; 2) PMTCT Form I; and 3) PMTCT Form II.

The data that is being collected by facilities is reported as per provincial and national levels and is supported to be used at the local level for provincial and facility-based planning and monitoring. However, recent (2015) routine monitoring visits conducted by the National STI/HIV Unit to the provincial hospitals, health centres and clinics have revealed that the roll-out of many data-collection tools is discouraging regular reporting due to the workload. This is an area that the HIV concept note intends to strengthen, by supporting the roll-out and training of all health workers on the updated HIS reporting tool and database, and strengthening regular supportive supervision by the national STI/HIV Unit.

Looking forward, the MHMS plans to decentralise the health-information system in the three most populous provinces, namely Guadalcanal, Malaita and Western; and to provide parallel management-strengthening support through the Health Sector Support Programme (HSSP). This will provide a platform to improve provincial and facility planning, monitoring and management.

In the area of strategic information and data for decision making, the planned DFAT-funded poverty and health-outcome study, and the recent UNICEF-funded Second Generation Sentinel Surveillance (SGSS) study for HIV and STIs will be important sources of evidence for identifying health vulnerability, as will the *Monash University* costing study which includes measurement of out-of-pocket spending on health. All three studies will be important to inform stronger pro-poor, pro-key populations and inclusive programming.

Currently, the National STI/HIV Unit uses the MHMS reporting systems to monitor HIV cases. HIV treatment is being monitored through patient-monitoring systems, including regular CD4 counts and clinical examinations. Through a newly approved HIV grant from Global Fund starting in 2017, programme implementation through civil society partners – which comprise a considerable proportion of the programme – will be monitored through M&E tools and an automated management-information system, which will be developed as part of the proposed grant. This programme M&E system and tools will allow ongoing monitoring of service delivery through CSO partners who will report to the MHMS using existing reporting systems within the MHMS. A national HIV/STI database will be established as the central repository of all HIV/STI-related data, and will be linked to the national Health information system (HIS).

M&E capacity development will be implemented at various levels: overall reporting capacity will be strengthened through training of health-care staff at the facility level in all Provinces. This also includes strengthening of electronic information-reporting infrastructure. In addition, civil society service providers will be trained in M&E and reporting.